Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: KANSAS

Citation	4.41 Resident Assessment for Nursing Facilities	
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b)	The State is using:
	____	the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	X	a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

State of Kansas
Department of Social and
Rehabilitation Services

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
Background Information at Intake/Admission

State of Kansas
Department of Health
and Environment

MS-2100
10-91

FACILITY _____

I. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	First: (M.I.) Last:	
2.	DATE OF CURRENT ADMISSION	Month - Day - Year	
3.	MEDICARE NO. (SS# or Comparable No. if no Medicare No.)		
4.	FACILITY PROVIDER NO.	Federal No.	
5.	GENDER	1. Male 2. Female	
6.	RACE/ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of hispanic origin	
7.	BIRTHDATE	Month - Day - Year	
8.	LIFETIME OCCUPATION		
9.	PRIMARY LANGUAGE	Resident's primary language is a language other than English 0. No 1. Yes _____ (Specify)	
10.	RESIDENTIAL HISTORY PAST 5 YEARS	*(Check all settings resident lived in during last 5 years prior to admission)* Prior stay at this nursing facility Other nursing facility/residential facility MH/psychiatric setting MR/DD Setting NONE OF ABOVE	 a. b. c. d. e.
11.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem? 0. No 1. Yes	
12.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD Status, that were manifested before age 22, and are likely to continue indefinitely.)* Not Applicable - no MR/DD (Skip to Item 13) MR/DD with Organic Condition Cerebral palsy Down's syndrome Autism Epilepsy Other organic condition related to MR/DD MR/DD with no organic condition Unknown	 a. b. c. d. e. f. g. h.
13.	MARITAL STATUS	1. Never Married 4. Separated 2. Married 5. Divorced 3. Widowed	
14.	ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing facility 4. Other	
15.	LIVED ALONE	0. No 1. Yes 2. In other facility	
16.	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier Observation revealed additional information Resident unstable at admission	 a. b. c.

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1.	DATE OF CURRENT READMISSION	Month - Day - Year	
2.	MARITAL STATUS	1. Never Married 4. Separated 2. Married 5. Divorced 3. Widowed	
3.	ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2 Nursing facility 4. Other	
4.	LIVED ALONE	0. No 1. Yes 2. In other facility	

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

CUSTOMARY ROUTINE (Year prior to first admission to a nursing facility)

(Check all that apply. If all items are UNKNOWN, check box "Y")

1. CYCLE OF DAILY EVENTS	
Stays up late at night (e.g., after 9 pm)	a.
Naps regularly during day (at least 1 hour)	b.
Goes out 1+ days a week	c.
Stays busy with hobbies, reading, or fixed daily routine	d.
Spends most time alone or watching TV	e.
Moves independently indoors (with appliances, if used)	f.
Use of tobacco products at least daily	g.
NONE OF ABOVE	h.
2. EATING PATTERNS	
Distinct food preferences	i.
Eats between meals all or most days	j.
Use of alcoholic beverage(s) at least weekly	k.
NONE OF ABOVE	l.
3. HYGIENE PATTERNS	
In bedclothes much of day	m.
Wakens to toilet all or most nights	n.
Has irregular bowel movement pattern	o.
Prefers showers for bathing	p.
Prefers bathing in PM	q.
NONE OF ABOVE	r.
4. INVOLVEMENT PATTERNS	
Daily contact with relatives/close friends	s.
Usually attends church, temple, synagogue, (etc.)	t.
Finds strength in faith	u.
Daily animal companion/presence	v.
Involved in group activities	w.
NONE OF ABOVE	x.
5. UNKNOWN - Resident/family unable to provide information	y.

Signature of RN Assessment Coordinator: Date:

_____

Signatures of Others Who Completed Part of the Assessment:

_____

_____

_____

END

State of Kansas
Department of Social and
Rehabilitation Services

MINIMUM DATA SET PLUS FOR NURSING FACILITY RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)

(Status in the last seven days, unless otherwise indicated)

State of Kansas
Department of Health
and Environment

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10-91

FACILITY _____

Assessment Date ___ - ___ - ____ (Month - Day - Year)
Original (O) or Correction (#) ☐
Signature of
RN Assessment Coordinator _____

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	First: (M.I.) Last:	
2.	SOCIAL SECURITY NO.		
3.	MEDICAID NO. (If applicable)		
4.	MEDICAL RECORD NO.		
5.	REASON FOR ASSESS-MENT	1. Initial admission assessment 2. Hosp./Medicare reassessment 3. Readmission, not Medicare 4. Annual assessment 5. Significant change in status 6. Quarterly 7. Other (e.g., UR)	
6.	CURRENT PAYMENT SOURCE(S) FOR STAY	(Billing Office to code payment sources) 0. Not Used 1. Per Diem 2. Ancillary 3. Both Medicaid ☐ VA ☐ Medicare ☐ Self pay/Private insur. ☐ CHAMPUS ☐ Other ☐	
7.	RESPONSI-BILITY/ LEGAL GUARDIAN	(Check all that apply) Legal guardian a. ☐ Other legal oversight b. ☐ Durable power attrny./ health care proxy c. ☐ Family member responsible d. ☐ Resident responsible e. ☐ NONE OF ABOVE f. ☐	
8.	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Living will a. ☐ Do not resuscitate b. ☐ Do not hospitalize c. ☐ Organ donation d. ☐ Autopsy request e. ☐ Feeding restrictions f. ☐ Medication restrictions g. ☐ Other treatment restrictions h. ☐ NONE OF ABOVE i. ☐	
9.	DISCHARGE PLANNED WITHIN 3 MOS.	(Does not include discharge due to death) 0. No 1. Yes 2. Unknown/uncertain	
10.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced	

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(Persistent vegetative state/no discernable consciousness) 0. No 1. Yes (Skip to SECTION H.)	
2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK - seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK - seems/appears to recall long past 0. Memory OK 1. Memory problem	
3.	MEMORY/ RECALL ABILITY	(Check all that the resident is normally able to recall during last 7 days) Current season a. ☐ Location of own rm. b. ☐ Staff names/faces c. ☐ That he/she is in a nursing facility d. NONE OF ABOVE are recalled e.	
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	Made decisions regarding tasks of daily life 0. Independent - decisions consistent/reasonable 1. Modified independence - some difficulty in new situations only 2. Moderately impaired - decisions poor; cues/supervision required 3. Severely impaired - never/rarely made decisions	
5.	INDICATORS OF DELIRIUM - PERIODIC DIS-ORDERED THINKING/ AWARENESS	(Check if condition over last 7 days appears different from usual functioning) Less alert, easily distracted a. Changing awareness of environment b. Episodes of incoherent speech c. Periods of motor restlessness or lethargy d. Cognitive ability varies over course of day e. NONE OF ABOVE f.	
6.	CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities - in last 90 days 0. No change 1. Improved 2. Deteriorated	

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(With hearing appliance, if used) 0. Hears adequately - normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situation only - speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing	
2.	COMMUNI-CATION DEVICES/ TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used a. Hearing aid, present and not used b. Other receptive comm. technique used (e.g. lip read) c. NONE OF ABOVE d.	
3.	MODES OF EXPRESSION	(Check all used by resident to make needs known) Speech a. ☐ Writing messages to express or clarify needs b. ☐ Signs/gestures/ sounds c. ☐ Communication board d. American Sign Language or Braille e. Other f. NONE OF ABOVE g.	
4.	MAKING SELF UN-DERSTOOD	(Expressing information content - however able) 0. Understood 1. Usually understood - difficulty finding words or finishing thoughts 2. Sometimes understood - ability is limited to making concrete requests 3. Rarely/Never understood	
5.	SPEECH CLARITY	Speech unclear 0. No 1. Yes	

EXAMPLE:
Code the appropriate response = ☐
Check all the responses that apply = a. ☐

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Resident: _____ SS#: _____ Facility #: _____

SECTION C. CONT.

6.	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content - however able)* 0. Understands 1. Usually understands - may miss some part/ intent of message 2. Sometimes understands - responds adequately to simple, direct communication 3. Rarely/never understands	
7.	CHANGE IN COMMUNICATION/ HEARING	*Resident's ability to express, understand or hear information has changed over last 90 days* 0. No change 1. Improved 2. Deteriorated	

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. Adequate-sees fine detail, including regular print in newspapers/books 1. Impaired - sees large print, but not regular print in newspapers/books 2. Highly impaired - limited vision, not able to see newspaper headlines, appears to follow objects with eyes 3. Severely impaired - no vision or appears to see only light, color, or shapes	
2.	VISUAL LIMITATIONS/DIFFICULTIES	Side vision problems - decreased peripheral vision: (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights, sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	*Glasses; contact lenses; lens implant; magnifying glass* 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)* VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS Tearfulness, emotional groaning, sighing, breathlessness	b.
		Motor agitation such as pacing, handwringing or picking	c.
		Pervasive concern with health	d.
		Recurrent thoughts of death - e.g., believes he/she about to die, have a heart attack	e.
		Suicidal thoughts/actions	f.
		Failure to eat or take medications	g.
		Withdrawal from self-care, leisure activities	h.
		Reduced communications	i.
		Early morning awakening with unpleasant mood	j.
		NONE OF ABOVE	k.

2.	MOOD PERSISTENCE	*Sad or anxious mood intrudes on daily life over last 7 days - not easily altered, doesn't "cheer up"* 0. No 1. Yes	
3.	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		a. WANDERING (moved with no rational purpose; seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
4.	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)* Resisted taking medications/injection	a.
		Resisted ADL assistance	b.
		Resisted eating	c.
		NONE OF ABOVE	d.
5.	BEHAVIOR MANAGEMENT PROGRAM	*Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints and/or psychotropic medications in this category.)* 0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6.	CHANGE IN MOOD	*Change in mood in last 90 days* 0. No change 1. Improved 2. Deteriorated	
7.	CHANGE IN PROBLEM BEHAVIOR	*Change in problem behavioral signs in last 90 days* 0. No change 1. Improved 2. Deteriorated	

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SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		Adjusts easily to changes in routine	g.
		NONE OF ABOVE	h.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with and/or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family or friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Avoids interactions with others	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b
		NONE OF ABOVE	c.

SECTION G. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., no naps or naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	NONE OF ABOVE	d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most more than 2/3 of time		2. Little less than 1/3 of time	
		1. Some 1/3 to 2/3 of time		3. None	
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.		
		Day/activity room	b.	Outside facility	d.
		Inside NF/off unit	c.	NONE OF ABOVE	e.
4.	GENERAL ACTIVITY PREFERENCES (Adapted to resident's current abilities)	*(Check all activities preferences whether or not activity is currently available to resident)*			
		Cards/other games	a.	Going outdoors (walking/ wheeling/sitting)	h.
		Crafts/arts	b.		
		Exercise/sports	c.		
		Music	d.	Watch TV	i.
		Read/write	e.	Gardening/plants	j.
		Spiritual/religious activities	f.	Talking/conversing	k.
		Trips/shopping	g.	Helping others	l.
				NONE OF ABOVE	m.

5.	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses or indicates preferences for other activities or choices. 0. No 1. Yes	
6.	ISOLATION ORDERS	Resident is under medical orders for isolation which prohibits participation in group activities. 0. No 1. Yes	

SECTION H. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE *(Code for resident's PERFORMANCE over all shifts during last 7 days - Not including setup)*
0. INDEPENDENT - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days.
1. SUPERVISION - Oversight, encouragement, or cueing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days
2. LIMITED ASSISTANCE - Resident highly involved in activity, received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 3+ times - OR - More help provided only 1 or 2 times during last 7 days.
3. EXTENSIVE ASSISTANCE - While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times:
- Weight-bearing support
- Full staff performance during part (but not all) of last 7 days
4. TOTAL DEPENDENCE - Full staff performance of activity during entire 7 days.

			1 Self Perf	2 Support
2.	ADL SUPPORT PROVIDED *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)* 0. No setup or physical help from staff 1. Setup help only 2. One-person physical assist 3. Two + persons physical assist			
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces - to/ from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	LOCOMOTION	How resident moves between locations in his/ her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e.	EATING	How resident eats and drinks (regardless of skill)		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

TN#MS-92-12 Approval Date MAY 18 1992 Effective Date MAY 01 1992 Supersedes TN#_____

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SECTION H. CONT.

3.	BATHING	a. How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below. Use support codes on preceding page. (1 S P / 2 S) 0. Independent - No help provided 1. Supervision - Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence	
		b. Tub/whirlpool bath [a.] Shower [b.] Bed bath [c.] Bath lift [d.] NONE OF ABOVE [e.]	
4.	BODY CONTROL PROBLEMS	*(Check all that apply during last 7 days)* Balance - partial or total loss of ability to balance self while standing [a.] Bedfast all or most of the time [b.] Hemiplegia/ hemiparesis [c.] Quadriplegia [d.] Arm - partial or total loss of voluntary movement [e.] Hand - lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) [f.] Leg - partial or total loss of voluntary movement [g.] Leg - unsteady gait [h.] Trunk - partial or total loss of ability to position balance, or turn body [i.] Amputation [j.] NONE OF ABOVE [k.]	
5.	CONTRACTURES	*(Check all that apply in the prior 7 days)* Contractures - None [a.] Contractures - Face/Neck [b.] Contractures - Shoulder/Elbow [c.] Contractures - Hand/Wrist [d.] Contractures - Hip/Knee [e.] Contractures - Foot/Ankle [f.]	
6.	MOBILITY APPLIANCES/ DEVICES	*(Check all that apply during last 7 days)* Cane/Walker [a.] Brace/Prosthesis [b.] Wheeled self [c.] Other person wheeled [d.] Lifted (manually/ mechanically) [e.] Transfer aid (slide brd) [f.] Trapeze [g.] NONE OF ABOVE [h.]	
7.	TASK SEGMENTATION	Resident requires that some or all of ADL activities be broken into a series of sub-tasks so that resident can perform them. 0. No. 1. Yes	
8.	CHANGE IN ADL FUNCTION	Change in ADL function in last 90 days 0. No change 1. Improved 2. Deteriorated	

9.	ADL FUNCTIONAL REHAB. POTENTIAL	Resident believes he/she capable of increased independence in at least some ADLs [a.] Direct care staff believe resident capable of increased independence in at least some ADLs [b.] Resident able to perform tasks/activity but is very slow [c.] Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL) [d.] Self-performance restricted due to absence of assistive devices (e.g., brace or wheelchair) [e.] Tires noticeably during most days [f.] Active avoidance of activity for which resident is physically/cognitively capable (e.g., fear of falling) [g.] NONE OF ABOVE [h.]	

SECTION I. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES	*(Code for resident performance over all shifts.)* 0. CONTINENT - Complete control 1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT - BLADDER, 2 + times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. INCONTINENT - Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
2.	INCONTINENCE RELATED TESTING	*(Skip if resident's bladder and bowel continence codes equals 0/1 and no catheter used)* Resident has been tested for a urinary tract infection [a.] Resident has been checked for presence of a fecal impaction [b.] There is adequate bowel elimination [c.] NONE OF ABOVE [d.]	
3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan [a.] External (condom) catheter [b.] Indwelling catheter [c.] Intermittent catheter [d.] Did not use toilet rm/ commode/urinal [e.] Pads/briefs used [f.] Enemas/irrigation [g.] Ostomy [h.] NONE OF ABOVE [i.]	
4.	CHANGE IN URINARY CONTINENCE	Change in urinary continence, appliances, and/or programs in last 90 days 0. No change 1. Improved 2. Deteriorated	

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SECTION J. SKIN CONDITION AND FOOT CARE

1.	STASIS ULCER	Open lesion caused by poor venous circulation to lower extremities 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Record the number of sites for presence of each stage of pressure ulcers. If none are present at the stage stated, record "0" (zero) in the space provided. Code all that apply to resident during last 7 days.)*	No. at Stage
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.	
3.	HISTORY OF RESOLVED/ CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days. 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	Skin desensitized to pain, pressure, discomfort	a.
		Abrasions, bruises	b.
		Burns (second or third degree)	c.
		Surgical wounds	d.
		Cuts (other than surgery)	e.
		Open lesions other than stasis/pressure ulcers, or cuts	f.
		Rashes	g.
		NONE OF ABOVE	h.
5.	ACTIVE SKIN CARE PROGRAM	Protective/preventive skin care	a.
		Turning/repositioning program	b.
		Pressure relieving beds,bed/chair pads (e.g., egg crate pads)	c.
		Surgical wound or pressure ulcer care	d.
		Other skin care/treatment	e.
		Special nutrition/hydration program	f.
		Special application/ointments/medications	g.
		Ostomy care (e.g., trach) (routine/stable)	h.
		NONE OF ABOVE	i.
6.	SPECIAL STOCKINGS	During the past 7 days has the resident used TED or similar stockings? 0. No 1. Yes	
7.	FOOT CARE	*(Check all that apply to resident during LAST 30 DAYS)*	
		Protective/preventive Foot Care: (e.g., special shoes, inserts, pads, toe separators, nail/callus trimming, etc.)	a.
		Active Foot Care Treatments:	
		Foot Soaks	b.
		Dressing with and without topical medications, etc.	c.
		NONE OF ABOVE	d.

SECTION K. DISEASE DIAGNOSES/CONDITIONS

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/inactive diagnoses.)

1. DISEASES *(If none apply, check the NONE OF ABOVE box)*

HEART/CIRCULATION		PSYCHIATRIC/MOOD	
Arteriosclerotic heart disease (ASHD)	a.	Anxiety disorder	p.
Cardiac dysrhythmias	b.	Depression	q.
Congestive heart failure	c.	Manic depressive (bipolar disease)	r.
Hypertension	d.	SENSORY	
Hypotension	e.	Cataracts	s.
Peripheral vascular disease	f.	Glaucoma	t.
Other cardiovascular disease	g.	OTHER	
NEUROLOGICAL		Allergies	u.
Alzheimer's	h.	Anemia	v.
Dementia other than Alzheimer's	i.	Arthritis	w.
Aphasia	j.	Cancer	x.
Cerebrovascular accident (stroke)	k.	Diabetes mellitus	y.
Multiple Sclerosis	l.	Explicit terminal prognosis	z.
Parkinson's disease	m.	Hypothyroidism	aa.
PULMONARY		Osteoporosis	bb.
Emphysema/ Asthma/COPD	n.	Seizure disorder	cc.
Pneumonia	o.	Septicemia	dd.
		Urinary tract infection in last 30 days	ee.
		NONE OF ABOVE	ff.

2. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____

3. PROBLEMS CONDITIONS AND SIGNS/ SYMPTOMS *(Check all problems that apply; last 7 days, UNLESS OTHER TIME FRAME STATED)*

Constipation	a.	Recurrent lung aspirations in last 90 days	j.
Diarrhea	b.	Shortness of breath (Dyspnea)	k.
Dizziness / vertigo	c.	Syncope (fainting)	l.
Fecal impaction	d.	Vomiting	m.
Fever	e.	Respiratory infection	n.
Hallucinations /delusions	f.	Chest Pain	o.
Internal bleeding	g.	NONE OF ABOVE	p.
Joint pain	h.		
Pain - Res. complains or shows evidence of pain daily or almost daily	i.		

4. EDEMA *(Check all that apply in the last 7 days)*

Edema - none	a.
Edema - generalized	b.
Edema - localized not pitting	c.
Edema - pitting	d.
Edema - other	e.

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SECTION K. CONT.

5.	ACCIDENTS	*(Check all that apply)*			
		Fell - past 30 days	a.	Other fractures in last 180 days	d.
		Fell - past 31-180 days	b.	NONE OF ABOVE	e.
		Hip fracture in last 180 days	c.		
6.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating.			a.
		Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem.			b.
		NONE OF ABOVE			c.

SECTION L. ORAL/NUTRITION STATUS

1.	ORAL PROBLEMS	a. Chewing problem			a.
		b. Swallowing problem			b.
		c. Mouth pain			c.
		d. NONE OF ABOVE			d.
2.	HEIGHT AND WEIGHT	a. Record height in inches		HT (in.)	
		b. Record weight in pounds		WT (lb.)	
		Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice - e.g., in a.m. after voiding before meal, with shoes off, and in nightclothes.			
		c. Weight loss (i.e., 5% plus IN THE PAST 30 DAYS or 10% IN THE PAST 180 DAYS): 0. No 1. Yes			
3.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.	Regular complaint of hunger	d.
		Insufficient fluid; dehydrated	b.	Leaves 25% + food uneaten at most meals	e.
		Did NOT consume all/almost all liquids provided during last 3 days	c.	NONE OF ABOVE	f.
4.	NUTRITIONAL APPROACH	Parenteral/IV	a.	Therapeutic diet	e.
		Feeding tube	b.	Diet supplement between meals	f.
		Mechanically altered diet	c.	Plate guard, stabilized built-up utensil, etc.	g.
		Syringe (oral feeding)	d.	NONE OF ABOVE	h.

SECTION M. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures and/or removable bridge	b.
		Some/all natural teeth lost - does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers, or rashes	e.
		Daily cleaning of teeth/dentures	f.
		NONE OF ABOVE	g.

SECTION N. SPECIAL TREATMENTS, DEVICES, PROC., & SUPPLIES

1.	SPECIAL TREATMENTS AND PROCEDURES	*a. SPECIAL CARE - (Check treatments received during the last 14 days.)*			
		Chemotherapy	a.	Transfusions	g.
		Radiation	b.	O2	h.
		Dialysis	c.	Intake/Output	i.
		Suctioning	d.	Ventilator/Respirator	j.
		Trach care	e.	Other _____	k.
		IV meds.	f.	NONE OF ABOVE	l.

b. THERAPIES - Record the number of days and total minutes each of these therapies was administered (for at least 10 minutes) in the last 7 days (0 if none)

Box A = # of days administered for 10 mins. or more
Box B = Total # of minutes administered in last 7 days

	A	B
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Psychological therapy (any licensed prof.)		
e. Respiratory therapy		
f.. Recreation therapy		

2.	REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation/restorative technique/practice was provided for more than or equal to 15 minutes per day, to the resident in the last 7 days. (Enter 0 if none)*	
		a. Range of Motion (passive)	
		b. Range of Motion (active)	
		c. Splint/Brace Assistance	
		d. Reality Orientation	
		e. Remotivation	
		Training and Skill Practice in:	
		f. Locomotion/Mobility	
		g. Dressing/Grooming	
		h. Eating/Swallowing	
		I. Transfer	
		j. Amputation Care	
3.	DEVICES AND RESTRAINTS	*Use the following code for last 7 days:* 0. Not used 1. Used less than daily 2. Used daily	
		a. Bed rails	
		b. Trunk restraint	
		c. Limb restraint	
		d. Chair prevents rising	

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SECTION N. CONT.

4.	SUPPLIES	*Record the number of units of the supply listed that have been used or consumed by the resident in the past 7 days. (Enter 0 if none)*	
		a. Sterile Dressings	
		b. Unique/Special Decubitus Care Supplies	
		c. Peritoneal Dialysis Supplies	
5.	PHYSICIAN ORDERS	IN THE LAST 30 DAY PERIOD since the resident was admitted, how many times has the physician (authorized assistant/practitioner) changed the resident's orders? (Do not include order renewals without change.)	
6.	NO LAB TEST	*Check if no laboratory tests performed in the last 90 days. (Skip to Section O)*	
7.	LABORATORY TEST	How many lab samples (blood/urine/etc.) have been collected IN THE PAST 30 DAYS?	
8.	ABNORMAL LAB RESULTS	a. How many laboratory tests were returned with abnormal values during the past 90 days?	
		b. How many abnormal values resulted in treatment or care planning in the past 30 days?	

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	*Record the number of different medications used in the last 7 days. (Enter "0" if none used. Skip to item 5.)*	
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days. 0. No 1. Yes	
3.	INJECTIONS	*Record the number of days injections of any type received during the last 7 days.*	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*Record the NUMBER OF DAYS during the last 7 days; enter "0" if not used; enter "1" if long acting meds. used less than weekly*	
		a. Antipsychotics	
		b. Antianxiety/hypnotics	
		c. Antidepressants	
5.	PREVIOUS MEDICATION RESULTS	*Skip this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics - otherwise code correct response for last 90 days* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences.) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

SECTION P. PARTICIPATION IN ASSESSMENT

1.	PARTICIPATE IN ASSESSMENT	Resident: 0. No 1. Yes		Family: 0. No 1. Yes 2. No Family		Significant Other: 0. No 1. Yes 2. None

P.2. SIGNATURES OF THOSE COMPLETING THE ASSESSMENT:

a. Name of RN assessment coordinator _____ b. End Date _____

	Signature	Title	Sections	Date
c.				
d.				
e.				
f.				
g.				
h.				

P.3. CASE MIX GROUP

Medicare [ ][ ][ ][ ] State [ ][ ][ ][ ]

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SECTION Q: MEDICATIONS LIST

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the resident's treatment regimen

1. List the medication name and the dosage.

2. RA (Route of Administration). Use the appropriate code from the following list:

1 = by mouth (PO)	6 = rectally
2 = sublingual (SL)	7 = topical
3 = intramuscular (IM)	8 = inhalation
4 = intravenous (IV)	9 = enteral tube
5 = subcutaneous (SubQ)	10 = other

3. FREQ (Frequency): Use the appropriate frequency code to show the number of times per day that the medication was given.

PR = (PRN) as necessary	4D = (QID) four times daily	C = continuous
1H = (qh) every hour	5D = five times daily	
2H = (q2h) every two hours	1W = (QWeek) once every week	
3H = (q3h) every three hours	2W = twice every week	
4H = (q4h) every four hours	3W = three times every week	
6H = (q6h) every six hours	QO = every other day	
8H = (q8h) every eight hours	4W = four times every week	
1D = (qd or hs) once daily	5W = five times every week	
2D = (BID) two times daily (includes every 12 hours)	6W = six times every week	
	1M = (QMonth) once every month	
3D = (TID) three times daily	2M = twice every month	

4. PRN—n (prn- number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

5. DRUG CODE: Enter the eleven digits of the National Drug Code (NDC). NOTE: If using the NDC's in the Manual Appendix, the last two digits of the 11 digit NDC define package size have been omitted from the codes listed in the Manual Appendix. If using the Appendix, the NDC should be entered left-justified (the first digit of the code should be entered in the space farthest to the left of the NDC code column.) This should result in the last two spaces being left blank.

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	NDC Codes
EXAMPLE: Coumadin 2.5mg	1	1W		
Digoxin 0.125 mg	1	1D		
Humulin R 25 Units	5	1D		
Robitussin 15cc	1	PR	2	

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Resident: _____ SS#: _____ Facility #: _____

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	NDC Codes

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